

GEORGIA BOARD OF DENTISTRY
A Division of the Department of Community Health
2 Peachtree St., N.W., 36th Floor
Atlanta, GA 30303

(Duplicate form as needed)

TO THE REFERENCE: The person listed below is applying for licensure as a dentist in the State of Georgia. The applicant is required to furnish satisfactory evidence that he/she is qualified to practice professional dentistry. You have been given this form as one who knows the applicant well and can attest to his/her character, ability, reputation, and professional attainments. The statements you proved must be from personal knowledge only. You should answer fully, carefully, and with the utmost frankness. Be assured that the information you furnish is **confidential**. Please return your recommendation directly to the applicant. **RETURN TO APPLICANT IN A SEALED ENVELOPE.**

NAME OF APPLICANT _____

FROM _____
Reference Full Name (Daytime telephone # including area code)

Address

City State Zip Code

1. Are you a licensed dentist? ____ Yes ____ No If yes, what state(s)? _____

If no, what is your present profession? _____

2. How long have you known the applicant? _____ years Are you related? _____

3. In what capacity have you known him/her? _____

4. Do you know anything reflecting adversely on the applicant's integrity or general good character?
____ Yes ____ No **If yes, give details on a separate page.**

5. Do you feel that this applicant is qualified to have responsibility of a dental office?
____ Yes ____ No **If no, give details on a separate page.**

6. Would you feel comfortable going to this person for your dental needs?
____ Yes ____ No **If no, give details on a separate page.**

7. What is the applicant's character, reputation, and standing in the community? _____

NAME OF APPLICANT_____

REFERENCE NAME_____

Additional Comments_____

The undersigned certifies that the above statements, to the best of his/her knowledge and belief, are correct.

Signature

Title

Date